INFORMATION

C.P.S.—Its Strengths and Weaknesses

The following, a supplement to the annual report of the Board of Trustees of California Physicians' Service that was published in the March 1961 issue of CALIFORNIA MEDICINE, *was delivered at the 1961 Annual Session of the House of Delegates by Dr. John G. Morrison, chairman of the board.*

CALIFORNIA'S Blue Shield Plan was a pioneer, born in ferment, reared like Topsy, and only now appears to be reaching a stage of stable maturity. Your Board of Trustees feels that, in this era of maturity, the economic arm of the medical profession in California has an enormous undeveloped potential to further benefit the public and the profession.

To guide our course in the critical years ahead, the House of Delegates of the California Medical Association, the ultimate governing body of C.P.S., must, as never before, be aware of the strengths and weaknesses of your organization as seen by your Board of Trustees. I would like to briefly outline these today.

The foremost area of strength lies in our physician membership. Chart 1 shows the proportion, as of March, 1961, of all practicing physicians in the state who are members of C.P.S. The growth in number of practicing physicians as well as fluctuation in proportion of C.P.S. physician membership, at five-year intervals from 1940 through 1960, are shown in Chart 2.

This membership record seems to us all the more remarkable in light of the fact that a very great number of these physicians were too young to have experienced the flux and political furor which accompanied the establishment of this pioneer Blue Shield Plan. I think one can assume certain things from these facts—one, that medical socioeconomic pressures in 1961 closely resemble those of 1939, and, two, that this voluntary association reflects a sober, unemotional, professional appreciation of the necessity for this particular type of prepayment mechanism in our present and foreseeable economy.

When I say, "this particular type of prepayment mechanism," I refer to service benefits, a type of prepaid health plan for which there is increasing public pressure and demand. In California, C.P.S. is the only statewide mechanism which can meet this demand. Alternatives are either closed panels or arrangements of county societies available only within local areas.

A second great area of strength lies in our flexibility to adapt to change—change in the patterns of medical practice as well as change in the public's need. The voluntary sacrifice of a minor amount of individual economic self-determinism on the part of physician members has provided us with a corporate structure which has been relatively free to engage in pilot plans and other experimentation. With full use of these prerogatives and with physician support, we believe it possible to continue in the development of patterns of prepaid medical care previously considered impossible. The direct benefits to the public thus derived, not to mention the salutory effect on other underwriters of health insurance, cannot be measured in dollars alone.

A third area of strength lies in our subscriber membership as well as their loyalty to C.P.S. Chart 3 shows the fluctuation in patient membership. The first reduction in membership between 1950 and 1955 reflects the after-effects of the statewide split between C.P.S. and Blue Cross. The second dip two-

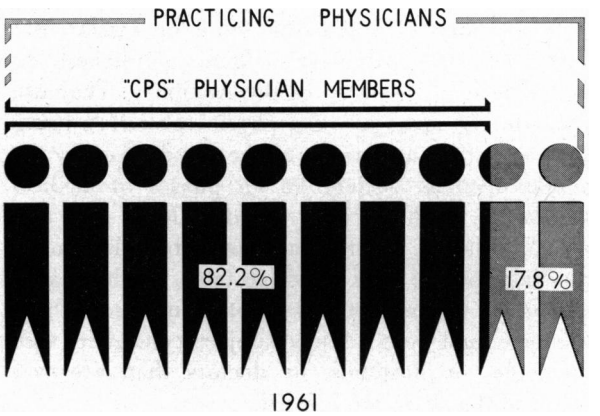

Chart 1.—The proportion, as of March, 1961, of practicing physicians in California who were members of California Physicians' Service.

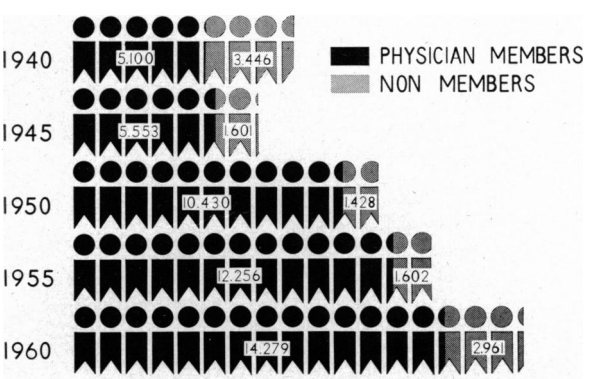

Chart 2.—Fluctuation in number of practicing physicians, as well as proportion of C.P.S. physician membership, at five-year intervals from 1940 through 1960. The reduction in number of practicing physicians in 1945 was due to the war.

thirds of the way between 1955 and 1960 reflects the economic recession of 1958. At the end of 1960, membership in the commercial programs stood at 971,068 persons.

Chart 4 shows the current C.P.S. patient membership structure. Under government, C.P.S. is administering as fiscal agent the Veterans Hometown Care Program, the Medicare Program, and a portion of the Public Assistance Medical Care Program.

As to subscriber loyalty, I should point out that the first two large groups to enroll in C.P.S., the California State Employees and Stacey's, Inc., are still on our books. Many other groups, including the California State Grange, have been with us for many years.

The proportion of California's population that has health coverage of one kind or another is shown in Chart 5, which also shows where this part of the population obtains its prepaid medical care. This chart demonstrates rather dramatically the relatively small (about 6 per cent) proportion of the population covered by C.P.S. in California. What it cannot portray—and I wish it could—is the considerable influence this insured group exerts on the other underwriters in this field, influence evidenced by upgrading of benefits and a more accurate coverage of both the public and the profession's needs in the entire field of prepaid health care.

In any self-appraisal, then, duration of membership, current enrollment and stature in the field must be considered as indices of C.P.S.'s effectiveness and vitality. By all these standards, I can report for your Board of Trustees, we measure up very creditably.

My report of C.P.S. strength would not be complete without further mention of our work with various government agencies. I have already mentioned our role as fiscal agents for the Veteran, Medicare and Public Assistance programs. Chart 6 shows the proportional relationship of payments made under these governmental programs to those in our commercial plans. This chart also depicts the growth between 1955 and 1960 in the volume of medical care provided by C.P.S. to government beneficiaries. It should also be noted that in 1955 the only governmental program administered by C.P.S. was that of the Veterans Administration. Participation in the varied governmental programs that we serve today gives us an opportunity to keep abreast of their thinking and future planning in this field as well as giving us access to valuable actuarial data. Through our provision of these fiscal services, tax dollars have been saved by low administrative cost and avoidance of the need of duplication of equipment and personnel on the part of the government.

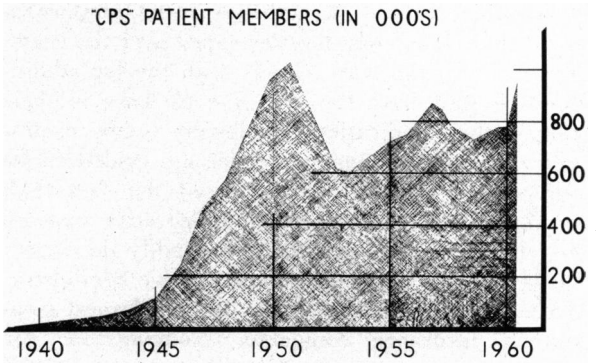

Chart 3.—Fluctuation in C.P.S. patient membership. The first reduction in membership midpoint between 1950 and 1955 reflects the effects of the statewide split between C.P.S. and Blue Cross. The second dip two-thirds of the way between 1955 and 1960 reflects the economic recession of 1958.

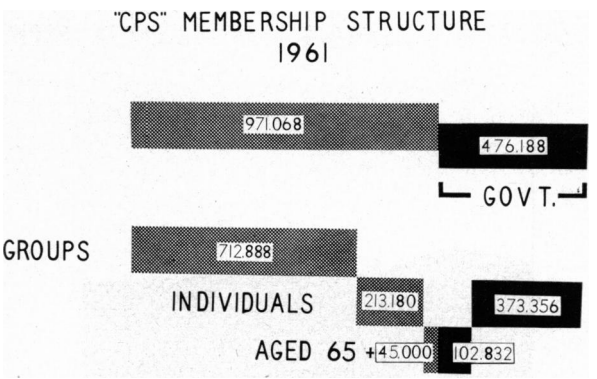

Chart 4.—Current C.P.S. patient membership structure. Under government contracts, C.P.S. is administering as fiscal agent the V.A. Program, the Medicare Program (which provides medical care for the dependents of the Armed Forces) and the Public Assistance Medical Care Program. The C.P.S. coverage of 45,000 in its own programs for those 65 years of age and over include persons still in groups, in extension of coverage by conversion and those individually enrolled.

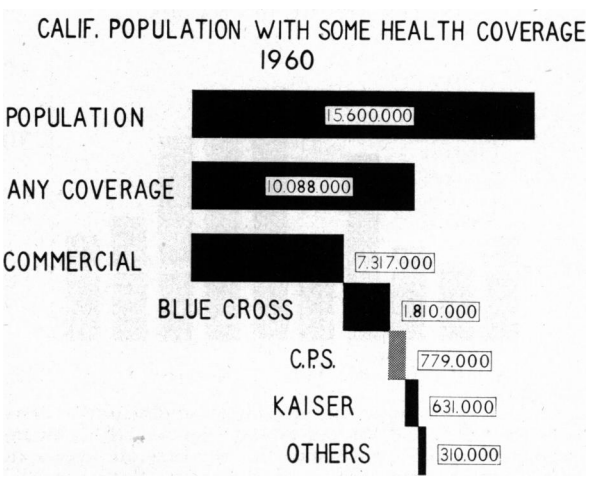

Chart 5.—Showing the proportion of California's population with health coverage of any type. Also shown is where this part of the population obtains its prepaid medical care.

Our final area of strength lies in the administrative "know how" that has developed over the years. Those of us who work closely with the lay administrative staff have the utmost confidence in their ability, their dedication and loyalty to the profession. Reasons for our confidence are evidenced by our strong financial position and the fact that, despite rising labor costs, administrative expense in relation to dues income has steadily decreased. Chart 7 shows a comparison of relative administrative costs between C.P.S. and the ten largest commercial insurance companies. Company A, for example, shows an administrative expense of 15 per cent, Company F shows 36.6 per cent. Incidentally, the volume of medical coverage written in 1960 varies between $406,601,000 for Company A and $88,195,000 for Company F during the calendar year 1960. As you can see, C.P.S.'s administrative expense of about 10 per cent compares favorably, and we are expecting even greater reductions in future years. The importance of this administrative expense ratio is made more dramatic by Chart 8, which shows a comparison of the portion of the income dollar returned to the patient in actual medical care as between C.P.S. and the 12 companies with the largest volume of health insurance in California. For example, of a total of $133,000,000 in individual hospital and medical premiums paid in this state between 1957 and 1958, slightly less than $61,000,000 was paid out in actual benefits. This amounts to only 46 cents of the dollar collected. During the same period, C.P.S. returned more than 80 cents on the dollar. Competent administration, then, permits us to expend maximal amounts of the dues dollar for services rendered, which, again, is evidence of our strength.

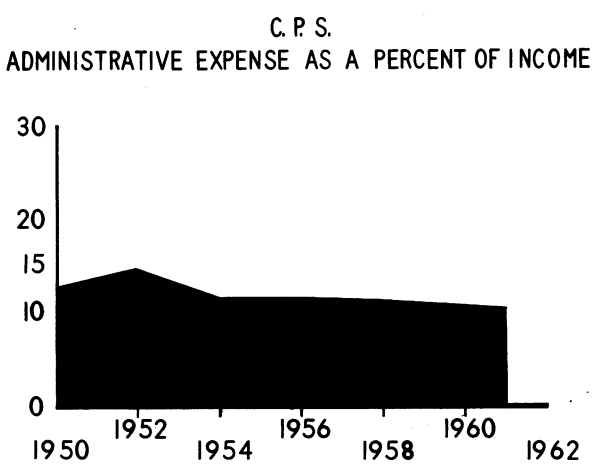

Chart 6.—C.P.S. administrative expense shown as a per cent of C.P.S. income since 1950. The reduction in administrative cost is apparent especially if the peak of 1952 is taken into consideration.

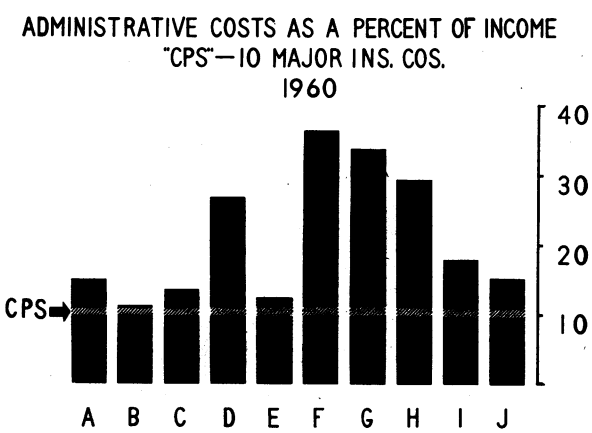

Chart 7.—A comparison of relative administrative costs between C.P.S. and the ten largest commercial health insurance companies. Company "A," for example, shows an administrative expense of 15 per cent. Company "F" shows 36.6 per cent. Incidentally, the volume of medical coverage written in 1960 varies between $406,601,000 for Company "A" and $88,195,000 for Company "F" during the calendar year 1960.

In summary, then, these are our main strengths: Physician membership, flexibility and freedom to experiment, subscriber loyalty, the ability to deal with government, and administrative "know how."

The weaknesses are less numerous but are critically important. Over the past several years, the absence of realistic and uniform fee schedules and income provisions has been a severe handicap to C.P.S. in enrolling statewide and national groups. The old ratification process was painfully slow, and

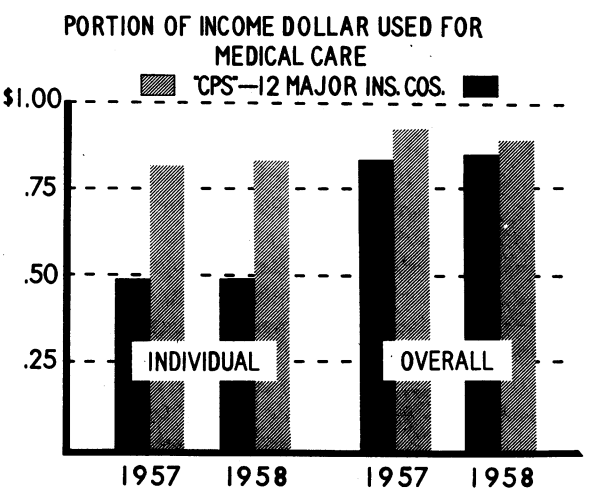

Chart 8.—A comparison of the portion of the income dollar returned to patient membership in actual medical care between C.P.S. and the twelve companies with largest volume of health insurance earned income in California. For example, of a total of $133,000,000 worth of individual hospital and medical insurance written in California between 1955 and 1958, slightly less than $61,000,000 (or only 46 cents on the dollar collected) was paid out in actual hospital and medical care benefits. During the same period C.P.S. returned more than 80 cents on the dollar. This slide shows similar comparison for individual policies and the overall of group and individual policies for 1957 and 1958.

not only inhibited C.P.S.'s ability to market effectively, but also delayed the introduction of more adequate fee schedules for professional services.

On studying this matter, the C.M.A.-C.P.S. Liaison Committee, which was formed as a result of action of this House last year, made recommendations to improve the fee schedule situation. With the C.M.A. Council's subsequent authorization to market two new fee schedules (D and E) on a statewide basis, the problem has been significantly improved.

Even so, the fee schedule picture is extremely complex. There are some 15 different fee schedules now in effect around the state—some available statewide, some available in single counties only, and some available in a group of counties. With this degree of fragmentation, many marketing problems still exist, and it is not difficult to visualize the problem which existed only a short time ago when only the lowest schedule was available statewide. These facts have given great comfort and satisfaction not only to C.P.S. competition, but also to backers of governmental schemes.

Another weakness that plagues all prepayment service organizations, including C.P.S., is the problem of educating the public as to the danger of experience rating.

The cost of a given prepaid or insured contract depends, for example, upon the type of underwriter (service or indemnity), the type of contract (group or nongroup), the range of benefits, geographic differences in hospital charges and physicians' fees, and the characteristics of the particular group or individual risk.

In recent years, the last factor, the characteristics of the specific risk, has become particularly important and has spread the practice of differential pricing (or experience rating) that was developed by the insurance industry, a practice that discriminates against the coverage of the marginal risk.

Sociologically, this situation is dynamite, and if the trend toward experience rating cannot be reversed, it is most probable that an explosion will occur which will demand, and in a large measure justify, government intervention. This is abundantly clear to the Blue plans, but they cannot reverse it alone. The insurance industry, the public, and the profession must help, too—and so far they have shown little intent to do so.

At present, C.P.S. is attempting to ride two horses in this regard, by "pooling" or community rating the higher risks (such as Continued Membership, small groups and contracts issued to individuals) and experience rating the highly competitive preferred risk groups. How much longer it can continue this practice is open to conjecture, since in bidding for preferred risk groups no allowance is

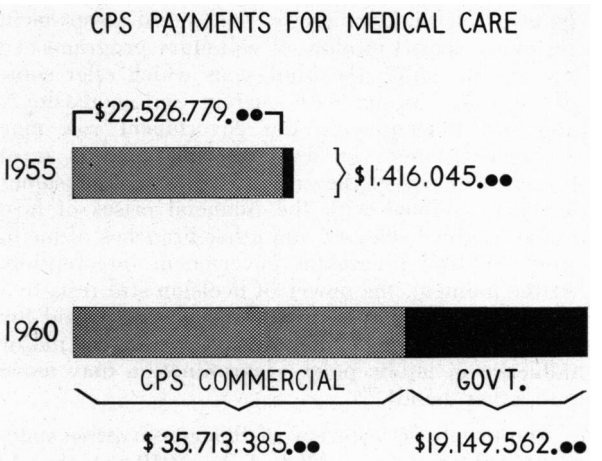

Chart 9.—The growth in volume of medical care provided by C.P.S. in 1955 and 1960. It should be noted here that the only government program administered by C.P.S. in 1955 was the V.A. program, while in 1960 C.P.S. administered the V.A., Medicare and Public Assistance Medical Care.

made by competition for expenses involved in meeting a social responsibility. This weakness—that is, being forced into experience rating—must be combated by intensive education of the public and the profession as to its potential danger. With unified support of the profession, C.P.S. is in a unique position to provide the leadership in this highly sensitive and important area of medical economics in the 60's.

The last and most disturbing weakness I wish to mention is in the area of professional relations, namely, physician support of the profession's creative imagination. We are weak and vulnerable as never before in this particular context. Many give only lip service to Blue Shield philosophy. Some confuse freedom and responsibility with free enterprise and the profit motive. Some apparently have memories of past injustices longer than their vision of accomplishment for the future. Only in our House of Delegates can these issues be faced and decided on their merits, but unity and cooperation on whatever decisions are made by the House were never more obviously necessary.

The problems that will face Medicine and C.P.S. during the decade ahead will be many and varied, just as they have been in the past. Some can be anticipated and planned for. Of these, the principal one is the position of government in the medical care field. What will it be, what will it mean to the medical profession and to voluntary prepayment? An answer may be found in a paragraph from the Somer's study of Private Health Insurance, published by the Institute of Industrial Relations, University of California, Berkeley:

"In the crucial stage of evolution immediately ahead, voluntary health insurance may determine

its own role and, indirectly, the role of government for many years to follow. If voluntary programs can succeed in taking the bold steps which offer some promise for coping with current and increasingly apparent inadequacies, the government role may continue in more or less the same pattern as at present. Otherwise, the growing volume of consumer demand, coupled with the financial crises of hospitals, medical schools, and other branches of medicine will lead to greater government intervention. At the moment, the power of decision still rests to a major extent with the providers of service and the insurance carriers. If they default or fail, the major influence in public policy determination may move into other hands."

The prophetic accuracy of this conservative statement, which was published in 1958 is already apparent in the plans of the present national administration.

If our national economic goal continues to be full employment—and it undoubtedly will— the demand for full service comprehensive benefits will become more and more insistent. A nation obliged to consume the goods and services of full employment will be so involved in the problem of financing purchases that any unexpected expense will upset the family budget. Even today, most families live from pay check to pay check. So it takes no special insights to recognize that full service programs with comprehensive benefits will be in increasing demand, not because of public caprice, but because of very real economic pressures. It can be safely predicted that this demand will be satisfied in one way or another. We should be planning accordingly to offer such programs before we lose the chance.

In this and other areas of future planning, C.P.S. is uniquely prepared with actuarial data to do the research necessary for the development of new programs. But, as an agency of the medical profession, it must have broad and affirmative physician support if it is to market them effectively. By the word "effectively" is meant not only the successful conduct of the initial enrollment, but the maintenance of public satisfaction with a given program at the point of service. To the extent that such satisfaction is maintained, to that extent will Medicine's freedoms remain unchallenged by political proposals. But let us not forget, ever, that the final decision will be the public's.

Tumor Boards in California

The 1961-1962 Approved List

THE COMMISSION ON CANCER of the California Medical Association has actively promoted tumor boards for more than thirty years. Minimum standards and general guides for the operation of tumor boards have been published. The objectives of a tumor board are to offer consultation on cancer diagnostic and therapeutic problems to physicians of the hospital medical staff and the community, and to actively engage in a professional education program, utilizing whenever possible the experiences of the board as the focal point of the program.

The medical director of the commission surveys the tumor boards and presents his findings for action to the Committee on Consultative Tumor Boards, the section of the commission responsible for this phase of cancer control. The following list of tumor boards has been approved by the Commission on Cancer and the Council of the California Medical Association for 1961-1962. Copies of the Minimum Standards may be obtained from the Commission on Cancer, California Medical Association, 693 Sutter Street, San Francisco 2.

The asterisk (*) indicates provisional approval. The tumor boards so listed have not fully met the standards for lack of time, inadequate case volume or other acceptable reasons, and this designation does not reflect upon the board.

TUMOR BOARDS IN CALIFORNIA

Approved by the Commission on Cancer of the California Medical Association

ALAMEDA COUNTY:
- Berkeley
  - *Herrick Memorial Hospital
- Castro Valley
  - *Eden Hospital
- Oakland
  - Highland-Alameda Hospital
  - Kaiser Foundation Hospital
  - *Peralta Hospital
  - Samuel Merritt Hospital

KERN COUNTY:
- Bakersfield
  - Kern County General Hospital
  - *Mercy Hospital and Nursing Home

BUTTE-GLENN COUNTIES:
- Chico
  - Butte-Glenn Tumor Board

LOS ANGELES COUNTY:
- Burbank
  - St. Joseph Hospital

*Asterisk denotes provisional approval.